STATE OF IOWA
WORKERS' COMPENSATION STATUS REPORT

NOTE TO INJURED EMPLOYEE: YOU MUST PROVIDE THIS FORM TO YOUR TREATING PHYSICIAN TO COMPLETE AT THE TIME OF TREATMENT. YOU ARE RESPONSIBLE FOR RETURNING THE COMPLETED FORM TO YOUR SUPERVISOR.

NOTE TO MEDICAL PROVIDER: IN ORDER TO EXPEDITE THE HANDLING OF THIS CLAIM, PLEASE FAX THIS REPORT TO: SEDGWICK CMS AT (515) 327-4899. YOU MAY REACH SCMS AT (866) 342-3920 FOR BILLING INFORMATION AND APPROVAL OF REFERRALS.

Patient: _____ Date Seen: _____
State Agency: _____ Date Injured: _____
Diagnosis: _____ Physician: _____

- ❑ Unable to perform any work
- ❑ Fit for full duty on: _____
- ❑ Fit for modified duty* on _____

- ❑ Anticipated return to work
  Full duty: _____
  Modified duty: _____

Work Restrictions: (These restrictions are for work and non-work activities)

- ❑ No lifting over _____ lbs.
- ❑ Avoid repetitive bending and twisting.
- ❑ No overhead work.
- ❑ Sit down duties only.
- ❑ Standing and walking as tolerated.
- ❑ No use of _____.
- ❑ No repetitive or forceful gripping, pinching or wrist motions with hand:
  ❑ Right ❑ Left ❑ Both
- ❑ Keep wound clean and dry.
- ❑ No overtime work.
- ❑ Keep splint on _____.
- ❑ No driving or operating dangerous equipment.
- ❑ No kneeling or squatting.
- ❑ Limit keyboard use to _____.
- ❑ Avoid exposure to _____.
- ❑ No pushing or pulling.

*If work that satisfies the above limitations cannot be provided, the patient is not to work and should return as scheduled.

Medication: _____
Physical Therapy _____
_____

- ❑ To return to clinic _____ days, weeks, months Date: _____ Time: _____
- ❑ Referred to _____
- ❑ Discharged from treatment on _____
- ❑ No permanent impairment anticipated.

_____ _____
Physician Signature Date

_____ _____
Patient Signature Date

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